| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| 1 | General | How long should a facility keep Validation Reports? | The validation reports remain available via CASPER for a year. CMS does not have any requirement on this issue.<br><br>Keep as long as the facility feels they need proof of validation. |
| 2 | Interviews | Is it required to have the original hard copy of the interviews in the resident record or is it enough to enter the interview responses into the MDS on the computer & put in the MDS software note, details on responses and staff who were interviewed? | Staff interview yes, resident interviews no.<br><br>Based on overall MDS 3.0 requirements, all items coded on the MDS3.0 require support documentation in the clinical record with the exception of resident interviews.<br><br>Section D: (Look back period is 14 days)<br><br>When it is determined that the resident was not able to be interviewed based on documented inability or unwillingness of the resident to complete the PHQ-9© Resident Mood Interview, the "staff should complete the PHQ-9-OV© **Staff Assessment of Mood** in these instances so that any behaviors, signs, or symptoms of mood distress are identified." (See Page D-11) "Alternate means of assessing mood must be used for residents who cannot communicate or refuse or are unable to participate in the PHQ-9© **Resident Mood Interview**. This ensures that information about their mood is not overlooked." (See Page D12)<br><br>Follow steps for Assessment on page D12 of the manual. Step one requires: "Interview staff from all shifts who know the resident best." The use of "Care Tracker" is not considered a staff interview and cannot stand alone to support validation requirements for the MDS 3.0. Documented staff interviews must accompany the Care Tracker in order to validate coding at D0500 columns 1 and 2, A through J. A documented interview is one that is dated, signed by the interviewer, identifies the person interviewed and what they said. |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| 3 | Payment | We had been told that when a Medicare resident transfers to a lower level of care and is covered by Mainecare, that the Z0200 score for the last PPS assessment that was completed could be used for RUGS billing until the next OBRA assessment was due. What happens if the last PPS assessment was a COT MDS (using the NO form) which doesn't have a Z0200 score? Should the last Z0200 score that was generated be used for billing purposes? | For MaineCare payment, facilities are supposed to use the OBRA assessment in effect at that time. So if the resident is Medicare and changes to MaineCare, the payment group used for MaineCare payment is from the admission (or significant change or quarterly) not the most recent PPS assessment. That rate will stay in effect until the next OBRA assessment is completed. |
| 4 | Submission | When a resident is private pay what assessments if any are required to be submitted? | All OBRA Schedule assessments are required for all residents, regardless of pay source (RAI Manual, page 1-11). The OBRA schedule is found in the RAI Manual on pages 2-15 & 2-16. |
| 5 | Submission | When assessments have been submitted and accepted for residents that are private pay only, what are the correction procedures? | The correction policy (MDS 3.0 Section X) is to be utilized for all assessments that are identified as having an error, regardless of pay source (RAI Manual, pages X-1 through X-11).<br><br>If an assessment is submitted for the wrong reason please contact the help desk at 287-5882. |
| 6 | Submission | We have a gero-psych unit that has a separate provider number. When a resident is transferred to one of our other units do we have to do a discharge MDS from the gero-psych and restart the whole MDS process with an admission MDS? | No. As long as the units have the same Medicare number (A0100B), you do not need to discharge and admit a resident when they move from unit to unit. You need to update A0100C on the next assessment for the resident. |
| 7 | Chapter 2 | If our facility discharges the resident after the | Continue to follow the MDS3.0 guidelines and requirements. The change in the State bed holds has nothing to do with the Federal |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| | | 4 day bed hold runs out.....Do we start them over as a new admission when and if they return to the facility? Example: Resident to hospital on 4/5 through 4/8.....is not ready to return and does not pay for bed hold 4/9 on.....Facility discharges them on 4/9.....resident returns to facility on 4/15. Is this resident now considered a new admission and will then require an admission MDS3.0? | MDS3.0 requirements. Please see the RAI Manual pages 2-7 through 2-15 and 2-35 through 2-36.<br><br>"Nursing home bed hold status and opening and closing of the medical record have no effect on these requirements" |
| 8 | A | A0310F<br><br>Resident is discharged return anticipated but does not return to facility. Should facility inactivate the return anticipated assessment and do a new return not anticipated assessment? Recently it was indicated at training that facilities need to inactivate a return anticipated assessment and do a return not anticipated assessment when the resident does not return to the facility. | Facilities are not to change the return anticipated assessment if the resident does not return to the facility. |
| 9 | A | When a resident goes to the emergency room and is admitted as observation status when does the clock start and stop for the purposes of determining if a discharge MDS must be done. The regulation says that a discharge is defined as "resident has a hospital observation stay greater than 24 | The clock should start when the resident is admitted to the emergency room. RAI Manual Chapter 2 page 2-12. |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| | | hours, regardless of whether the hospital admits the resident." Does the clock start when they are seen in the emergency room, or does the clock start when they are actually admitted as observation? | |
| 10 | A | If a resident is discharged return anticipated prior to completing the OBRA admission assessment, should the admission assessment be done after the resident returns? | If the OBRA admission assessment has not been completed prior to discharge, an admission assessment must be done when the resident returns to the facility. You do not need to do a discharge return anticipated to make it possible to do an admission assessment when then resident returns. See RAI Manual 2-7 for the situations where an OBRA admission assessment is appropriate. |
| 11 | A/O | Should the therapy work sheets be maintained for a longer period than the 7-day look back required for the PPS assessments? The facility has been having trouble tracking therapy time for determining whether a change of therapy assessment is necessary. They have implemented holding the work sheets for 30 days. | Having work sheets over a longer period of time is a good practice since, the therapies have to be evaluated every 7 days to determine whether a change of therapy assessment is needed. |
| 12 | B & C | What is the best way to provide appropriate documentation for sections B0700, C0700-1000? | All assessments to support coding these items are required to be documented in the clinical record in the 7 day look back period. The only areas of the MDS that do not require documentation in the record are resident interviews.<br><br>**B0700 - RAI Manual pages B-6 through B-7**<br><br>Follow steps for assessment on page B-7 record the resident's actual performance in making everyday decisions about tasks or |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| | | | activities of daily living. Enter one number that corresponds to the most correct response.<br><br>**C0700 – C1000 RAI Manual pages C-17 through C-25**<br><br>Follow steps for assessment on page C-23 record the resident's actual performance in making everyday decisions about tasks or activities of daily living. Enter one number that corresponds to the most correct response.<br><br>**C1000**<br><br>Follow steps for assessment on page C-23 record the resident's actual performance in making everyday decisions about tasks or activities of daily living. Enter one number that corresponds to the most correct response. |
| 13 | C | What happens when there needs to be a change in the ARD and you need to set a new date? Or you originally made a mistake in the ARD (set it too late/early) and realized the error several days after the actual assessment date. You could actually be off by one day. | Unless the assessment has been submitted to the ASAP system (CMS data collection system), the ARD can be updated to the appropriate date according to the internal policies and procedures for the facility.<br><br>If the assessment has been submitted to the ASAP system, you must inactivate that assessment and do a new assessment with a new ARD. See chapter 5 of the RAI manual. |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| 14 | C | If the resident answers the questions in the BIMS interview and receives a score of "0" on all questions, can C0500 be coded "00"? | Yes. "00" is a valid value for C0500. If the answers to C0200 and C0300 are coded "0" because the resident refuses to answer the questions, then C0500 would be coded "99" and C0400 would be filled with hyphens(-). However, if the questions are coded "0" because the resident is impaired, tries to answer the questions but cannot answer appropriately, then the interview can be completed and C0500 can be "00". |
| 15 | D | When interviewing a resident for question PHQ-9 D0200I, Thoughts That You Would Be Better Off Dead or of Hurting Yourself in Some Way: the resident answers " they wish they were gone" but deny any thoughts of hurting themselves do we code column 1 as yes or no? | The interview question has 2 parts – #1 thoughts that you would be better off dead and #2 thoughts of hurting self in some way. If the resident affirms either half of the scripted question, code column one as symptom present. Be careful to follow guidance in the RAI Manual in asking scripted questions and when the resident's answer is unclear to the questioner, explore further according to the manual guidance. See RAI Manual pages D-5 through D-6. |
| 16 | D | When interviewing a resident for question PHQ-9 D0200I, Thoughts That You Would Be Better Off Dead or of Hurting Yourself in Some Way: the resident answers " they wish they were gone" but deny any thoughts of hurting themselves do we code column 1 as yes or no? | The interview question has 2 parts; #1) thoughts that you would be better off dead; and #2) thoughts of hurting self in some way. If the resident affirms either half of the scripted question, code column one as symptom present. Be careful to follow guidance in the RAI Manual in asking scripted questions and when the resident's answer is unclear to the questioner, explore further according to the manual guidance. See RAI Manual pages D-5 through D-6. |
| 17 | G | We have a resident who has had recurrent bouts of pneumonia, likely aspiration, and has orders for strict aspiration precautions, to be upright for all meals, and to be supervised at all meals. This resident is supervised directly at all meals except one. He is so fatigued by 3-11 shift that he refuses to eat in | Code for Supervision even on the evening shift, as long as they are actually entering his room and providing the verbal cueing and oversight. We would expect that the care plan would specify the approaches to be used for the dining room meals and the in-room meals. The care plan should clearly direct staff supervision in each of these 2 environments. |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| | | a supervised environment, desiring to eat only in his room. Furthermore, he gets very upset if he perceives he is being watched while he eats (only notices in his room, not when he is in a group environment). Since eating during this time of fatigue creates an even higher risk of aspiration, the staff, while not wishing to appear as though they are monitoring, hover around the room frequently to cue small bites, assure upright position and to listen for any cough or choking that might indicate a potential problem.<br><br>Given the resident's history and the type of problem he has with swallowing, this level of supervision may not be optimal but is likely sufficient supervision for him. My question is….what is the definition of "supervision," for purposes of the MDS/care plan? Must it be in a group environment such as a dining room, constant one on one, or is intermittent monitoring and "checking in," from a distance (but not necessarily in the same room) permissible? The manual states that the cues etc. constitute supervision, but there is no clear statement as to whether or not the resident has to be in a group or 1:1 setting at the time he/she is being cued and monitored. | If the supervision occurred 3 or more times during the 7 day look back period for the ARD of the MDS 3.0, this would qualify for coding of supervision. This clearly describes supervision 3 or more times. As to the care plan, supervision does not have to be in a group environment.<br><br>RAI Manual for MDS3.0, pages G-1 through G-8 and G-15 thru G-16. In addition, care planning tips in Chapter 4 can be helpful in developing the resident's care plan. |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| 18 | G | I cannot use hospice aide ADL documentation to capture for my MDS window can I??<br><br>I have a lady who is very independent in all areas, but when hospice does her care they do more for her than we do..... | From the manual pages G3-G4: For the purposes of completing Section G, "facility staff" pertains to direct employees and facility-contracted employees (e.g. rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration. Therefore, facility staff does not include, for example, hospice staff, nursing/CNA students, etc. Not including these individuals as facility staff supports the idea that the facility retains the primary responsibility for the care of the resident outside of the arranged services another agency may provide to facility residents. |
| 19 | G | I am looking for clarification regarding coding G0400 (Functional Limitation in ROM).<br><br>Is a functional limitation in ROM code able despite the cause?<br><br>For example, guidance was received a while ago suggesting that a functional ROM limitation had to be due to paralysis/hemiparesis, contracture, or a very specifically documented limitation. However, many residents have ROM limitations that affect their ability to participate in ADLs or other activities that are more general or are not as specifically related to the joint/movement being assessed, such as:<br><br>1. a resident with an upper body tremor so severe that they require feeding or adaptive | G0400 should be coded regardless of cause of limitation. Follow guidance in the RAI manual on pages G-29 through G-32. You are coding for functional limitation not the cause.<br><br>On page G-31 the manual states: “Do not look at limited ROM in isolation. You must determine if the limited ROM impacts functional ability or places the resident at risk for injury…”<br><br>This item has a 7-day look back period. The manual states the following: “Review the medical record…Talk with staff members who work with the resident as well as family/significant others…Directly observe the resident…” <u>You must determine</u> if the limited ROM impacts functional ability or places the resident at risk for injury. Your determination should be qualified by your documentation in the resident’s record.<br><br>The manual states on page G-31, in the coding tips, “There are many amputees who function extremely well and can complete all ADLs either with or without the use of prosthetics. If the resident with an amputation does indeed have difficulty completing |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| | | equipment to eat<br><br>2. a resident who cannot complete a ROM exercise due to cognitive deficits<br><br>3. a resident with a more generalized condition such as OA that might limit ROM due to edema or even pain alone<br><br>Also, if the above are codeable as functional ROM limitations, must they occur every day over the look back period. i.e. Must Mr. J be fed every day due to upper body tremor due to Parkinson's Disease, or can this be coded if the limitation occurs on only some days during the look back period? Similarly, if Mrs. M cannot complete a ROM exercise due to cognitive limitations that vary from shift to shift and day to day?<br><br>Utensils that allow him to feed himself. The issue is still there and requires daily intervention by way of the adaptive equipment, but because of the adaptive equipment, the actual limitation no longer exists.<br><br>Finally, once a functional ROM area is addressed with adaptive equipment (when possible), is it still coded as a limitation? Example, Mr. J has severe tremors due to Parkinson's and could not feed himself.....he | ADLs…the facility should code this item as appropriate." You must assess the resident <u>as he is functioning</u> during the 7-day look back period. This would include his use of adaptive equipment. However, some residents, such as those with severe tremors or osteoarthritis will still be impacted by their limited functional ability, even with the use of their adaptive equipment. |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| | | then received adaptive utensils that allow him to feed himself. The issue is still there and requires daily intervention by way of the adaptive equipment, the actual limitation no longer exists. | |
| 20 | G | Please provide guidance on Active Diagnoses. My understanding is that for diagnoses to be considered active, they should be something that currently impacts the resident's treatment. Does daily preventive treatment alone make a diagnosis active or should this be considered in context of symptoms and monitoring required? For example, Mrs Q. receives ASA 325 mg daily due to a HX of CVA. The CVA occurred a long time ago and the resident appears to have recovered function fully, though is considered to remain at risk for a future CVA. Should this be considered an active diagnosis? Similarly, if a resident receives trimethoprim daily due to a history of chronic UTI's? Or ASA daily for prevention of clots in a resident with a history of CAD but yet receives no other treatment and has not experienced symptoms for a decade since a bypass, versus a resident who had a DVT ten months ago? | RAI manual page3 I-3 through I-4: "**Determine whether diagnoses are active:** Once a diagnosis is identified, it must be determined if the diagnosis is **active.** Do not include conditions that have been resolved or have no **longer** affected the resident's current functioning or plan of care, or that the resident has adjusted to as their "new normal," during the last 7 days…. **Active** diagnoses have a **direct** relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the look-back period."<br><br>Please note that infections have special qualifiers on pages I-5 through I-10. |
| 21 | G | What constitutes "supervision," of eating? Do the rules require a group eating environment | **"Code Supervision** for residents seated together or in close proximity of one another during a meal who receive individual |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| | | or direct 1:1 supervision, or does monitoring for upright position for all meals and similar count even though it may not require the direct presence of a staff member at the resident's meal at all times? | supervision with eating. General supervision of a dining room is not the same as individual supervision of a resident and **is not** captured in the coding for Eating." (MDS RAI manual page G-7).<br><br>Supervision for positioning is not taken into consideration when coding for the Eating ADL. |
| 22 | G | We had some controversy regarding the coding for eating skills. Staff would feed a resident a few bites of her food to get her started. They would give her the utensil to feed herself the rest of her meal. Is it considered a limited assist or an extensive assist where there is some weight bearing assist? | Feeding the resident part of the meal would qualify as extensive assist for that meal. The MDS 3.0 should be coded as extensive if this level of assist was documented as occurring at least (3) times in the 7-day look-back period. See RAI Manual G-1 through G-6 |
| 23 | G | If a resident is coded just once in the assessment reference period as supervision/set up for an ADL and is independent with that ADL all other times, is that ADL coded as 1/1 on the MDS? | Yes. Per the ADL Self Performance Algorithm on page G-6 of the RAI Manual, Code 0, Independent, only if "resident fully perform the ADL activity without ANY help or oversight from staff <u>every time</u>." If none of the rule of 3 conditions are met, code 1 supervision. RAI Manual, page G-6. |
| 24 | G | A patient has 3 different codes on ADL's: dependent, extensive and set (independent), how would you code? | You would code supervision because none of the rule of 3 conditions are met. |
| 25 | H | I was always under the impression that if the resident is on something scheduled for bowels, ie Senna, etc. that you could code under section H or also add it to section I. Is | The definition of constipation is: "If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements)." (RAI manual page |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| | | this still correct? Or, is it that the constipation is resolved when on medications, and only coding when giving prn meds? | H-12)<br><br>Coding instructions: "Code 0, no: if the resident shows no signs of constipation during the 7-day look-back period.<br>Code 1, yes: if the resident shows signs of constipation during the 7-day look-back period." (RAI manual page H-13)<br><br>If constipation is being effectively managed by medication, code 0 on H0600.<br><br>Constipation can be added to section I only if it meets the definition of an active diagnosis. |
| 26 | I | Do you have any guidance on what qualifies a person as having a Traumatic Brain Injury? We have a resident who we accepted from River Ridge. He was a victim of a stabbing. As a result of the stabbing the was either Hypoxic because of the blood loss or he was Apoxic because he went into severe cardiac arrest. We are still researching why he is now in a "vegetative state". I believe that both causes would be considered Traumatic Brain Injury. | The trauma must be to the head causing brain injury as diagnosed/verified by the physician in the last 60 days and active in the last 7 days. |
| 27 | K | The Manual states to use the weight closet to the 30 days or the 180 day point. Does that mean the weight could be at a date before day 30 or 180? | Yes. Use the weight measured on the date closest to day 30 and day 180 whether the date is before or after.<br><br>For example: if you have a weight that is 5 days prior to day 30 and one that is 10 days after day 30, use the weight from the 5 days prior to day 30. |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| 28 | M | Is Candidiasis of skin (in abdominal folds etc.) considered a Moisture Associated Skin damage and should we code it under M1040 along with the treatment under M1200? | According to the RAI manual (page M-32), "is caused by sustained exposure to moisture which can be caused, for example, by…perspiration."<br><br>There must be documentation that moisture is present and is a cause of moisture associated skin damage (MASD). Candidiasis by itself is not evidence of MASD in M1040H. |
| 29 | M | How do you code a pressure area where documentation says scab? | "Ulcer staging should be based on the ulcer's deepest visible anatomical level. Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a deeper stage than what is observed now, it should continue to be classified at the deeper stage. Nursing homes that carefully document and track ulcers will be able to more accurately code this item." (RAI manual page M-6).<br><br>If it is a new pressure area that has never been classified, and documentation indicates "scab", it would be coded as unstageable. See page M-15 in the RAI manual for further definition of unstageable pressure ulcers. |
| 30 | M | If a pressure ulcer opens in the same location, there are distinct requirements for coding. What is the period of time for closure of ulcer? Can this be clarified? | See Chapter 3, page M-27 of the manual. "If the prior assessment documents that a pressure ulcer healed between MDS assessments, but another pressure ulcer occurred at the same location, do not consider the first pressure ulcer to have healed, and do NOT record the pressure ulcer as healed." |
| 31 | M | Looking at the definition of "turning/repositioning program" in the manual and the intent doesn't seem quite clear. | 1-4 are approaches and not programs for turning and repositioning to treat identified skin and or ulcer conditions.<br><br>M1200: Skin and Ulcer Treatments |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| | | We have residents with the following orders:<br><br>1. Offload heels at all times for relief of pressure to heels.<br><br>2. Offload heels when out of bed for relief of pressure to heels.<br><br>3. Pillow between legs when sitting to prevent adduction of right hip.<br><br>4. Elevate legs when OOB – peripheral edema/impaired skin integrity.<br><br>All of these require repositioning and realignment of the body with a therapeutic effect expected.<br><br>All of these are documented, assessed, and reassessed as to efficacy.<br><br>All of these have time frames for application, though they are not the typical "whatever" or similar.<br><br>Which of these, if any, can or cannot be claimed as a turning/repositioning program?<br><br>I can see that number three is not specifically a skin/ulcer prevention treatment, but it certainly involves repositioning.<br><br>Numbers 1, 2, and 4, are to protect skin | "Appropriate prevention and treatment of skin changes and ulcers reduce complications and promote healing."<br><br>"These general skin treatments include basic pressure ulcer prevention and skin health interventions that are a part of providing quality care and consistent with good clinical practice for those with skin health problems."<br><br>M1200C Turning/Repositioning Program<br><br>"The 'program' must be a planned program. The program must specify frequency of interventions (which must be turning and position change interventions) over the 24 hour period, detail specifics of the program for 'skin and ulcer treatments' and evaluate the effectiveness of the treatments on the skin or ulcer condition(s). "<br><br>Casemix documentation needed: Goals, scheduled approaches, documentation that the approaches were delivered as planned, monitored and evaluation of the effect on the skin and/or ulcer conditions.<br><br>Do not confuse pressure relieving devices as programs. Alone, they do not meet the definition of turning and positioning. Merely elevating resident's legs to treat edema is not a program when it is considered alone. There must be a program.<br><br>RAI Manual M32 – 37. |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| | | integrity, we document the delivery of the intervention, and they are part of the skin integrity care plan. 1 and 2 for at-risk heels, 4 to prevent LE blistering associated w/increased edema.<br><br>How are you seeing this? I would appreciate your insight. | |
| 32 | M | A nursing facility has a resident who, as the result of an auto accident several years ago, had wires surgically placed in her sternum. The original surgical site has long since healed, but one of the wires is coming through the skin at the site, causing a small pinpoint opening that is draining. They are doing daily dressing changes to the site. It is unknown if this is due to an infection or rejection of the wire. Can this be coded as an open lesion? | After reviewing this Item in the Manual, it cannot be coded here. The reason is because even though it is from the inside to the outside, it is still a "cut/laceration" which is not allowed at M1040D. See RAI Manual page M-30 through M-31 |
| 33 | M | Can Neurodermititis also known as lichen simplex chronicus with recurrent cellulitis be coded at M1040D | Yes as long as it is open. See RAI Manual page M-31. |
| 34 | N | When coding psychotropic medications in section N you are supposed to code according to drug classification and not use. The benzodiazepines are classified under both anti-anxiety and sedative/hynotic. Which class are we | The name of the drug is needed to see if it is anti-anxiety or hypnotic. Some benzodiazepines are hypnotics and some are anxiety treatment medications.<br><br>For more information about specific classes of drugs, search on the web or call your consultant pharmacist. |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| | | supposed to use if we are not supposed to code by its use? Are we supposed to go by daily dose? | |
| 35 | O | We have a doctor that participates in IDT's, and I understand that this must be a physician exam, but is this allowed to be coded under visits? It also states in the manual that "included in this item are telehealth visits as long as the requirements are met for physician/practioner type as defined above and whether it qualifies as a telehealth billable visit." What does that mean? | The physician's participation can only be counted if there was an actual examination of the resident as defined on pages O-38 through O-39 of the RAI manual. Please see coding tips and special populations on O-39. |
| 36 | O | O0250C:<br><br>According to the manual we are supposed to go by the CDC website to determine when flu season starts and ends. How would I code O0250C if the CDC has determined that flu season in Maine has started mid September and the flu vaccine is available in our area but our Medical Director does not want any flu shots given until the end of October. Would I code 5 not offered or 9 none of the above? How would that affect the QM's? | Code 5: Not offered. The QMs reflect that the flu vaccine is not being offered. Once it begins to be offered to residents, both the short-stay and long-stay QMs will update to reflect the change. See http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS30QM-Manual.pdf. |
| 37 | O | Can we count a Doctor's visit that is | Yes. Electronic signatures are acceptable for coding on the MDS. |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| | | electronically signed? | |
| 38 | O | We have a resident that is trying to move out on his own. He has to be independent in everything. We are watching him at meal time to make sure he is taking 15 minutes to eat, whether or not he comes independently to get his medications. Would this be something that we can code in the monitoring part or skill training? | These activities should be documented in the resident's record, but there are no sections on the MDS 3.0 to capture training for "life skills." There is no Restorative nursing item (Section O0500) which captures medications, and the eating and/or swallowing item (O0500H) would have to be a plan specific to the actual process of eating, not the length of time it takes the resident to eat. |
| 39 | O/A | Should the therapy work sheets be maintained for a longer period than the 7-day look back required for the PPS assessments? The facility has been having trouble tracking therapy time for determining whether a change of therapy assessment is necessary. They have implemented holding the work sheets for 30 days. | Having work sheets over a longer period of time is a good practice since, the therapies have to be evaluated every 7 days to determine whether a change of therapy assessment is needed. |
| 40 | PPS | Entering the MDS in the system within 2 days of the ARD; if greater than 2 days, what is the consequence? Take the default rate? | Data entry practices are established by individual facility operating policies and procedures.<br><br>Please restate question if this refers to submission rather than data entry. |
| 41 | PPS | PPS assessment. Skilled therapy with restorative nursing in place to enhance therapy goals. Can we include the restorative nursing in the assessments? I have heard that we cannot include them as it | The MDS must be coded accurately. So if nursing restorative programs (RNP) are occurring, they must be coded. RNPs are counted to qualify for the Rehab low groups. However, in order to be counted, the RNPs must be coordinated and supervised by nursing staff not therapists (see manual page O-33). All other requirements |

| Number | Section/Topic | Question | Answer |
|---|---|---|---|
| | | would be “double-dipping”. | in the RAI manual must be met (pages O-32 through O-35). |
| 42 | PPS | I know we have up to grace day 8 to set the 5 day assessment ARD, but my question is, although we have 5 days of therapy between day 1 to 8, do we only count the minutes in the 7 day look back period (days 2 to 8) or can we count the minutes for all 8 days (days 1 to 8)? If we can’t use the minutes for day 1 we cannot achieve a rehab RUG score either because we need the 1st day of therapy or because we need the minutes of therapy provided on that day. | The look backup period is 7 days for all assessments. |